

**WISCONSIN MEDICAID  
PRIVATE DUTY NURSING / RESPIRATORY CARE SERVICES PRIOR AUTHORIZATION  
ACKNOWLEDGMENT**

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form.

**INSTRUCTIONS**

1. Allow the recipient, or recipient's parent, guardian, or legal representative, to read the plan of care and prior authorization (PA) request. Answer any questions the recipient may have.
2. Have the recipient or the recipient's legal health care designee sign and date this form.
3. Attach this completed form to the Prior Authorization Request Form (PA/RF) and/or Prior Authorization Amendment Request for private duty nursing (PDN) and/or respiratory care services (RCS).
4. For more information on PDN and RCS documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Name — Recipient	Wisconsin Medicaid Identification Number
Prior Authorization Number	

**I have read the attached Plan of Care and the PA request.**

Name — Person Signing Form (print)	Relationship to Recipient (if person signing form is not recipient)
<b>SIGNATURE</b>  Check one: <input type="checkbox"/> Recipient <input type="checkbox"/> Recipient's Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative	Date Signed